

**Attachment 2: Renewal notice for the individual market where coverage is being renewed in a QHP offered under the same product through the Exchange**

[1 Date]

[2 [First Name]][Last Name]  
[Address line 1]  
[Address line 2] [City][State]  
[Zip]]

**Important:** It's time to review your health coverage. **Update your [3 Exchange] application and pick a plan by [4 Date]**, or we'll automatically re-enroll you in the same or similar coverage for [5 Year]. This may change some of your costs and coverage, so review your options carefully.

Thank you for choosing [6 Issuer] for your health care needs. We're here to help you prepare for Open Enrollment.

## **Why am I getting this letter?**

We're still offering your health coverage in [7 Year], but some details may have changed. Read this letter carefully and decide if you want to keep this plan or choose another one, then update your application with [8 Exchange].

## **What's changing in [9 Year]?**

### **Your new premium**

- **Starting in [10 Month], your new monthly premium amount is estimated to be \$[11 Dollar amount].**

Here's the math: Monthly premium of \$[12 Dollar amount] minus [13 Phrase or dollar amount] of possible financial help. Your actual monthly premium amount may be different because your financial help may change in [14 Year]. You'll find out your new monthly premium when you get your [15 Month] bill.

**Important:** This estimated monthly premium is based on current information we have for [16 Year]. It might not account for some or all changes that could impact your monthly premium, like cost changes in your area for next year, or changes to your household income or family size. To find out the actual amount of your monthly premium, update your [17 Exchange] application. For more information about updating your application, go to "What should I do next?" below.

- Your [18 Current year] monthly premium amount is \$[19 Dollar amount].

Here's the math: Monthly premium of \$[20 Dollar amount] minus \$[21 Dollar amount] of financial help you get each month.

### Other changes

- [22 Briefly describe plan changes and/or refer to enclosed materials]
- You can review more details about your plan at [23 Issuer website] and in your [24 Year] Summary of Benefits and Coverage at [25 SBC web page].

## What should I do next?

### 1. Update your [26 Exchange] application by [27 Date].

Review your [28 Exchange] application to make sure the information is still current and correct, and make any necessary updates. After you submit your updated application, you'll find out if you qualify for more or less financial help than in [29 Year]. This could mean you'll pay a lower monthly premium amount or lower out-of-pocket costs (like deductibles, copayments, and coinsurance). Plus, you might not owe money when you file your taxes.

[30 For automatic re-enrollment of consumers whose premium tax credit amount resulted in a \$0 premium in the current benefit year] **Important:** Our records show you had a \$0 monthly premium amount in [31 Year]. You must update your application to qualify for a \$0 monthly premium amount in [32 Next Year]. Depending on your updated information, your [33 Next Year] monthly premium amount could still be higher than it was in [34 Current Year].

### 2. Decide if you want to enroll in this plan or choose another one.

#### ☐ I want to enroll in this plan.

Select [35 Plan name and ID] to enroll.

[36 For re-enrollment from a silver level QHP into a non-silver level QHP (except for Indian enrollees), insert: **Important:** This isn't a Silver plan in [37 Year]. This means you can't get financial help to lower your out-of-pocket costs if you stay in this plan. You must go back to [38 Exchange] and enroll in a Silver plan to find out if you qualify to get financial help. If you don't enroll in a Silver plan, any financial help you currently get to lower your out-of-pocket costs will end on December 31.]

#### ☐ I want to pick a different plan.

You can choose a different plan between [39 Dates]. Enroll by [40 Date] for coverage to start January 1. ]

Visit [41 Exchange website] to find other [42 Exchange] plans. Compare plans to save money and find one that best meets your needs and budget. Select the Plan name and ID of the plan you want to enroll in. You can also check with [43 Issuer] to find out what other plans may be available. Remember, you won't get financial help unless you qualify and enroll through [44 Exchange].

**Note:** If you got financial help in [45 Year] to lower your monthly premium, you must file Federal income taxes and “reconcile” the premium tax credit you qualified for with the amount you used during [46 Year]. If the amounts are different, it may change the amount of money you owe or get back when you file your Federal income taxes. To reconcile the premium tax credit, you must complete IRS Form 8962 “Premium Tax Credit (PTC)” and include it with your Federal tax return. For more information about the premium tax credit, visit: <https://www.irs.gov/affordable-care-act/individuals-and-families/the-premium-tax-credit-the-basics>.

## **We’re here to help**

- Visit [47 Exchange website], or call [48 Exchange phone number] to learn more about [49 Exchange] and find out if you qualify for lower costs.
- Call [50 Issuer] at [51 Issuer phone number] or visit [52 Issuer website].
- Find in-person help from an assister, agent, or broker in your community at [53 Website].
- [54 Contact an agent or broker you've worked with before [55 like Agent/broker name]. [56 Call Agent/broker phone number.]]
- Call [57 Exchange phone number] to get this information in an accessible format, like large print, braille, or audio, at no cost to you.

## **[58 Getting help in other languages]**

*[59 Insert non-discrimination notice and taglines consistent with any applicable State or Federal requirements. If there are no such requirements, see required non-discrimination notice and optional taglines.]*

**Instructions for Attachment 2 – Renewal notice for the individual market where coverage is being renewed under the same product in a QHP offered through the Exchange.**

**General instructions:**

This notice must be used when coverage was purchased through the Exchange and will be renewed under the same product through the Exchange, in accordance with 45 CFR 155.335(j). It doesn't need to display the OMB control number.

**Item 1.** Enter the date of the notice, in format Month DD, YYYY.

**Item 2.** Enter the full name and address of the primary subscriber. In the individual market, the primary subscriber means the individual who purchases the policy and who is responsible for the payment of premiums.

**Item 3.** Enter the Exchange name. For a Federally-facilitated Exchange, enter "the Health Insurance Marketplace®."

**Item 4.** Enter the date by which a plan selection must be made to avoid automatic re-enrollment, in format Month DD, YYYY

**Item 5.** Enter the following year, in format YYYY.

**Item 6.** Enter the issuer name.

**Item 7.** Enter the following year, in format YYYY.

**Item 8.** Enter the Exchange name. For a Federally-facilitated Exchange, enter "the Health Insurance Marketplace®."

**Item 9.** Enter the following year, in format YYYY.

**Item 10.** Enter the beginning month of the following benefit year.

**Item 11.** Enter the total monthly amount of premium for the enrollment group for which data are available for the following benefit year, minus the monthly amount of any advance payments of the premium tax credit paid on behalf of the enrollment group for which data are available.

**Item 12.** Enter the actual or estimated amount of monthly premium for the enrollment group for which data are available for the following benefit year.

**Item 13.** Enter the phrase "the same amount of financial help you're getting now" if the Exchange has not completed the annual eligibility redetermination by the time of providing the notice. If the Exchange has completed this redetermination by the time of providing the notice, enter the amount of advanced payments of the premium tax credit calculated from that redetermination.

**Item 14.** Enter the following year, in format YYYY.

**Item 15.** Enter the month in which the enrollee will receive a bill for the actual monthly payment for the following benefit year.

**Item 16.** Enter the benefit year from which financial information is being used to calculate the future year estimated premium amount, in format YYYY.

**Item 17.** Enter the Exchange name. For a Federally-facilitated Exchange, enter "Marketplace."

**Item 18.** Enter the current year, in format YYYY.

**Item 19.** Enter the most recent monthly amount of premium for the enrollment group for which data are available for the current benefit year, minus the most recent monthly amount of any advance payments of the premium tax credit paid on behalf of the enrollment group for which data are available.

**Item 20.** Enter the most recent monthly amount of premium for the enrollment group for which data are available for the current benefit year.

**Item 21.** Enter the most recent monthly amount of any advance payments of the premium tax credit paid on behalf of the enrollment group for which data are available. If the most recent ATPC paid on behalf of the enrollment group is zero, enter 0.

**Item 22.** List significant plan changes, including but not limited to changes in deductibles, cost sharing, metal level, covered services, eligibility, plan formulary and provider network. For the purpose of describing plan changes, the issuer may use the current cost-sharing reductions (CSR) eligibility if it has not received the updated CSR eligibility from CMS. This section may also refer to enclosed supplemental materials. Do not include the italicized instructions.

**Item 23.** Enter the issuer website.

**Item 24.** Enter the following year, in format YYYY.

**Item 25.** Enter SBC web page for the applicable plan.

**Item 26.** Enter the Exchange name. For a Federally-facilitated Exchange, enter “Marketplace.”

**Item 27.** Enter the date by which a plan selection must be made to avoid automatic re-enrollment, in format Month DD.

**Item 28.** Enter the Exchange name. For a Federally-facilitated Exchange, enter “Marketplace.”

**Item 29.** Enter the current benefit year, in format YYYY.

**Item 30.** Include this paragraph if an enrollee's portion of premium after advanced payments of the premium tax credit is \$0 for the current benefit year. Otherwise, omit and skip to item 35.

**Item 31.** Enter the current year, in format YYYY.

**Item 32.** Enter the following year, in format YYYY.

**Item 33.** Enter the following year, in format YYYY

**Item 34.** Enter the current year, in format YYYY.

**Item 35.** Enter plan name and HIOS Plan ID of plan into which the enrollee’s coverage will be renewed.

**Item 36.** Include this paragraph if the enrollee (except for Indian enrollees) is currently enrolled in a silver level QHP and their coverage is being renewed into a non-silver level QHP, consistent with 45 CFR 155.335(j). Otherwise, omit and skip to item 39.

**Item 37.** Enter the following benefit year, in format YYYY.

**Item 38.** Enter the Exchange name. For a Federally-facilitated Exchange, enter “the Marketplace.”

**Item 39.** Enter the beginning and end dates of the annual open enrollment period for the applicable benefit year, in format Month DD, YYYY.

**Item 40.** Enter the date by which a plan selection must be made for coverage effective January 1, in format Month DD, YYYY.

**Item 41.** Enter the Exchange website. For a Federally-facilitated Exchange, enter “HealthCare.gov.”

**Item 42.** Enter the Exchange name. For a Federally-facilitated Exchange, enter “Marketplace.”

**Item 43.** Enter the issuer name.

**Item 44.** Enter the Exchange name. For a Federally-facilitated Exchange, enter “the Marketplace.”

**Items 45-46.** Enter the current benefit year, in format YYYY.

**Item 47.** Enter the Exchange website. For a Federally-facilitated Exchange, enter “HealthCare.gov.”

**Item 48.** Enter the Exchange phone number. For a Federally-facilitated Exchange, enter “1-800-318-2596 (TTY: 1-855-889-4325).”

**Item 49.** Enter the Exchange name. For a Federally-facilitated Exchange, enter “the Marketplace.”

**Item 50.** Enter the issuer name.

**Item 51.** Enter the issuer phone number.

**Item 52.** Enter the issuer website.

**Item 53.** Enter LocalHelp.HealthCare.gov in a State with a Federally-facilitated Exchange. In other States, enter the appropriate website.

**Item 54.** Include this phrase if the enrollee has previously used an agent or broker to enroll. Otherwise, omit and skip to item 57.

**Item 55.** Enter “like” followed by the name of the agent or broker the enrollee has previously used, if known. Otherwise, omit and skip to item 57.

**Item 56.** Enter “Call” followed by the phone number of agent or broker the enrollee has previously used, if known. Otherwise, omit and skip to item 57.

**Item 57.** Enter the Exchange phone number and Exchange TTY number. For a Federally-facilitated Exchange, enter “1-800-318-2596 (TTY: 1-855-889-4325).”

**Item 58.** Insert “Getting Help in Other Languages” if adding a tagline pursuant to instruction item 59. Otherwise, leave blank.

**Item 59.** Insert a nondiscrimination notice and taglines consistent with any applicable State or Federal requirements, including Section 1557 of the Patient Protection and Affordable Care Act (Section 1557). If there are no such applicable nondiscrimination requirements, insert the following:

Health insurance issuers are prohibited from employing marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in health insurance coverage or discriminate based on an individual's race, color, national origin, present or predicted disability, age, sex, expected length of life, degree of medical dependency, quality of life, or other health conditions.

Taglines are optional but encouraged for issuers outside the Exchange if they are not subject to language access standards under applicable Federal or State law, including Section 1557. If there are no such applicable tagline requirements, the following optional tagline may be inserted:

**English: This notice has important information.** This notice has important information about your application or coverage through [Issuer]. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call [phone number].

#### **PRA Disclosure Statement**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0935-1254. This information collection is used by QHP issuers in the individual market to provide notice where coverage is being renewed in a QHP offered under the same product through the Exchange. The time required to complete this information collection is estimated to average 24 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection and provide the notice to individuals. This information collection is mandatory (45 CFR 147.106). This is

a third party disclosure, and the issue of confidentiality between third parties is out of scope for the collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850 or [Russell.tips@cms.hhs.gov](mailto:Russell.tips@cms.hhs.gov), Attention: Information Collections Clearance Officer.